Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969616	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE NAPLES	9015 BELLAIRE BAY DR NAPLES, FL 34120

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CZ821 SS=D	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3	CZ821		

to $50 per day late not to exceed $500.
(b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission.
(c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored.

This Statute or Rule is not met as evidenced by:
Based on record review, and staff interview, the facility failed to electronically submit a 1 day or 15 day adverse incident report as required for 3 (Residents #2, #9, #10) of 3 residents reviewed for adverse incidents.

The findings included:

Record review for Resident #2 revealed he had an unwitnessed on . The resulted in Resident #2's hospitalization, and subsequent surgery, due to a , that was obtained as a result of the . There was no adverse incident on record.

Resident #9 had an unwitnessed on at 10:20 a.m. Resident #9 was sent to the hospital and admitted due to a . There was no adverse incident on record.

Resident #10 had an unwitnessed on at 6:30 p.m. Resident #10 was sent to the hospital for assessment. Resident#10 obtained a left , , and hospitalized as a result of the that took place on . There was no adverse incident on record.

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CZ821	Continued From page 4 During an interview with the facility's Director of nursing (DON) on at 2:00 p.m. she acknowledged there was no adverse incidents submitted in regards to Resident #2, Resident #9, and Resident #10 incidents that resulted in hospitalizations. The DON said she was not aware of the regulatory requirement. During an interview with the Interim Administrator on at 4:00 p.m., she acknowledged the lack of documentation of adverse incidents filed for resident #2, #9, and #10. . Class III	CZ821		
A 000	Initial Comments An unannounced complaint # 2023006732, 2024001135, & 2024001568 and emergency power plan survey, was conducted on through , at Amira Choice Naples, an assisted living facility in Naples, Florida. Complaint # 2023006732 was not substantiated. Complaint # 2024001568 was substantiated at 0010 and 0032. Complaint # 2024001135 contained 2 allegations. One allegation was substantiated at 0025; and two allegations were not substantiated. The following is a description of the deficiencies. .	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency	A 010		

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A 010	Continued From page 5 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving	A 010		

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A 010	Continued From page 6	A 010		

hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.

59A-36.006
(4) CONTINUED RESIDENCY. Except as follows

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A 010	Continued From page 7	A 010		

in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:

(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.

(b) A resident requiring care of a , may be retained provided that:

1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.

(c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:

1. The resident qualifies for, is admitted to, and

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A 010	Continued From page 8	A 010		

consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.
(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on record review, and staff interview, the facility failed to update resident's health assessment after a significant change for elopement for 1 (Resident #4) of 4 residents reviewed.

The findings included:

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A 010	Continued From page 9 1. Record review for Resident #4 showed he admitted to the facility on . The initial Health Assessment Form 1823 dated , indicated diagnoses of Sensory hearing loss, mixed , , 's , , , enlarge , , , tremor, right , legally , and limited vision. Resident #4 was not deemed as elopement risk. Resident #4 resided at the facility's memory unit. 2. On at around 9:45 p.m., Resident #4 eloped from the facility's memory unit. The facility's Director of Nursing found Resident #4 sitting on his walker at the street across from the community. Resident #4 was able to go out of the memory unit due to a door . 3. Record review for Resident #4 found no evidence of an updated Health Assessment Form 1823 after the elopement that took place on . 4. Record review of the service plan in place for Resident #4 dated indicated the resident is and needs frequent redirection. Unlicensed staff to provide redirection as needed to manage & prevent elopement. 5. During an interview with the facility's Director of Nursing (DON) on at 1:00 p.m., she confirmed Resident #4's Health Assessment Form 1823 was not updated. The DON said she gave the updated Health Assessment Form to Resident #4's physician to complete and sign but she could not locate it. 6. During an interview with Resident #4's physician on at 2:30 p.m., he said he never	A 010		

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A 010	Continued From page 10 updated the Health Assessment Form for Resident #4 after the elopement that took place on . 7. During an interview with the Interim Administrator on at 3:00 p.m., she acknowledged that Resident #4 did not have an updated Health Assessment Form 1823 after the elopement which took place on . . Class III	A 010		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.	A 025		

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59A-36.007 Resident Care Standards.
An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.
(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:
(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.
(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record review, and staff interview, the facility failed to maintain documentation of an elopement investigation for 2 (Residents #2, #3) of 2 residents reviewed.

The findings included:

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A 025	Continued From page 12 Review of the facility Policy/Procedure titled: RESIDENT ELOPEMENT. Effective date: ,1.2022. . . . Procedure III .Response Protocol When a Resident is Suspected or Observed to be Missing. a. All staff Alert; Check of sign out Logs; and Family outreach. Upon the discovery that a resident is missing the facility's Executive Director or Director or Nurse on Duty shall alert all staff of this fact. Staff will check the sign-out log to verify that the resident has not provided notice of their departure from the facility, and will contact the resident's family to see if they picked up the resident or have any other information relevant to the resident's current location. . . . . Elopement Notifications Completed by Executive Director or Nurse on Duty. a. Law enforcement: The Executive Director or Nurse on Duty shall notify law enforcement approximately 30 (thirty minutes) after the discovery of the resident's disappearance. . . . c. The executive Director or Nurse on Duty shall notify the resident's family, significant other, guardian, health care surrogate, and case manger, if any, approximately thirty (30) minutes after the discovery of the resident's disappearance. 1. Review of Police report showed at on at around 11:00 p.m. a police officer was dispatched to the facility to perform a wellness check, after receiving a telephone call from Resident #2 and #3's granddaughter. At the time of the phone call, the deputy documented, the granddaughter was on the phone with both her grandparents. Per the deputy he was notified by the nurse in the facility that Resident #2 and #3 left earlier in the day and did not return yet. They did not sign out. Per the nurse on duty it was normal for them to leave the premises as	A 025		

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they had valid driver's licenses and a vehicle. In a follow up call with the resident's daughter the deputy documented that the vehicle was found in an area in Lee county. A silver alert was placed and the residents were found by the Deputy and returned to the facility on .

Record review found that Resident #2 and #3 (husband and wife) left the facility some time around noon. Resident #2 and #3 did not sign out before they left. Resident #2 and #3 had a valid drivers license and were able to drive independently. Further review found no evidence the facility staff contacted the resident's family after the noon medications on to ensure Resident #2 and #3 were out of the facility. There was no evidence that the facility's staff started looking for Resident #2 and #3 after p.m. medication given around 9:00 p.m. There was no evidence that the overnight nurse notified the Executive Director or Nurse of Resident #2 and #3's elopement. There was no evidence that the Executive Director or Nurse notified the resident's family. There was no evidence that the Executive Director or Nurse called law enforcement.

Record review showed that the facility's Director of Nursing (DON) was notified by the overnight nurse of Resident'#2 and #3's elopement on at around 8:00 a.m. Further review showed that Resident #2 and #3's daughter was the one that called the facility to let them know that she could not get in touch with her parents. Resident #2 and #3's daughter called the Sheriff for a wellness check, not the facility.

During an interview on at 11:00 a.m., the DON said Resident #2 and #3 were very independent, and had a tendency to go out with

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their car and that is why the staff in question did not worry. She said it was an Agency nurse, and she made a mistake. The DON said she was pretty sure that the previous ED had a record of calling the police. No record was provided. She also said she did not think that was an elopement since both were ambulatory consent adults and wanted to be out and about.

During a telephone interview with Resident #2's and #3's daughter on at 8:12 a.m., she said her parents were out to go to a doctor's , , , and then meet some friends. It was around 11:00 p.m. when her mother called her to tell her she was lost. She said while she was on the phone with her mother trying to find directions for her to go to the facility, the phone got disconnected. She assumed the battery . She called the facility to check if her parents were there. She was notified by the nurse they were not on the premises. She said the nurse did not seem worried. Resident#'2 and #3's daughter called the Sheriff not the facility. Resident #2's and #3's daughter said deputies placed a silver alert and her parents were found in a Hotel at Coconut Point on in the early hours.

During an interview with Resident #2's and #3's physician on at 2:30 p.m., he said he did not think that was an elopement since Resident #2 and Resident #3 were very alert and ambulatory. The physician added Resident #2 and #3 were not deemed as an elopement risk. The Physician said he was on the premises on Sunday around 7:00 a.m. when the Deputy brought the Residents . The physician assessed them and they told him that they wanted to go away and be alone. The physician also said the previous ED took her job very seriously and she had a whole binder with

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A 025	Continued From page 15 investigation of the event. No investigation was provided. During an interview with the Interim Administrator (ID) on at 3:00 p.m., she said the reason that the facility did not call the police was because Resident #2 and #3's daughter called first. The Interim Administrator said she did not think that was an elopement since Resident #2 and #3 were two consenting adults that were married and left. The ID said the only thing they did wrong was that they did not sign out. The Police report does not show any follow up calls from the Administrator in reference to Resident #2 and #3's elopement. . Class III	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement	A 032		

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A 032	Continued From page 16 for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement.	A 032		

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A 032	Continued From page 17 (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure elopement drills were conducted pursuant to Section 429.41(1)(k), F.S. The facility failed to ensure all administrative and direct care staff participated in the a minimum of 2 drills each annually, which must include a review of the facility's procedures to address resident elopement. The facility failed to ensure that residents who are deemed as an elopement risk have identification on their person that includes their name, the facility's name, address, and telephone number for 1 (Resident #4) out of 1 resident deemed as an elopement risk. The findings included: Review of the facility Policy/Procedure titled: Resident Elopement. Effective Date: . . Procedure: I. Elopement Training and Drills. b. Elopement Prevention and Response Drills. The facility will conduct a minimum of two (2) documented Elopement Prevention and Response Drills per year. At a minimum, all administrators and direct care staff shall participate in these drills, which shall include a review of the facility's [procedure to address Elopements. . . . II. Elopement Prevention Tasks Completed Upon the Resident's Admission to the Facility: e. Resident Identification. Staff will provide residents at risk of Elopement with identification that includes the resident's name, and the facility's name, address, and phone number. Staff will make daily effort to determine that these residents have their identification on	A 032		

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A 032	Continued From page 18 their person. Record review of below listed Facility Elopement drills revealed the following drills which all lacked the name of the participants (residents or staff) or evidence the policy and procedure was reviewed. Staff if participating are not named on the log even though the log shows staff name and positions are to be documented. On , "1 staff member and 1 resident in unit 115" was documented as participating in an Elopement Drill. On , "1 staff member, 5 Participants and 1 resident count was documented as participating in an Elopement Drill. On , "1 staff member, 5 Participants and 1 resident count was documented as participating in an elopement drill. On , "5 staff members, 4 Participants and 23 resident count was documented as participating in an elopement drill. On ./24, "3 staff members, 1 Participant, 2 visitor count. and 103 resident count was documented as participating in an elopement drill. On . "34 staff members , 1 Participant, 1 visitor count, and 95 resident count was documented as participating in an elopement drill. On , "13 staff members, 1 Participant and 91 resident count was documented as participating in an elopement drill. On , "2 staff members, and 85 resident count was documented as participating in an elopement drill. During an interview on at 11:03 a.m., the Maintenance Director said he is the person responsible for conducting the elopement drills, and they are completed on a monthly basis. He said he did not have a master list with all the employee names in order to ensure participation	A 032		

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in the elopement drills twice a year, and he was not aware of the regulatory requirement. He could not provide a signature list with the names of the staff who participated in the elopement drills provided. He said he did not keep track of that. The Maintenance Director confirmed he did not cover the elopement policy and procedure during the elopement drills.

Record review for Resident #4 revealed he was admitted to the facility on . Review of the initial Health Assessment Form 1823 for resident #4 dated , indicated diagnoses of Sensory hearing loss, mixed , , enlarged , tremor, right , legally . Limited vision. Resident #4 was not deemed as an elopement risk, and resided in the facility's memory care unit.

On at around 9:45 p.m. Resident #4 eloped from the facility's memory care unit. The Director of Nursing found the resident sitting on his walker at the street across from the community. Resident #4 was able to elope from the memory care unit due to a door . Review of the service plan in place for resident #4 dated , indicated resident #4 is and needs frequent redirection. Unlicensed staff to provide redirection as needed to manage & prevent elopement

On at 9:12 a.m., Observations were made of Resident#4 not wearing any identification on his person. Interview with private aid working for resident #4, confirmed resident #4 did not have any identification on his person.

During an interview on at 10:14 a.m., the Memory Care Director confirmed that Resident

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A	Continued From page 20 #4 did not have any identification on his person. She said she was aware of the regulatory requirement, but no resident met the criteria. The Memory care Director said no residents in the memory unit was deemed as an elopement risk. The Memory Care Director said there was no special instructions for resident #4 since he was not exit seeking. During an interview on . . . . at 10:45 a.m., Staff A confirmed that resident #4 did not have any identification on his person. Staff A said she was aware of the regulatory requirement, but no residents met the criteria. Staff A was not aware of any residents deemed as an elopement risk. Staff A said she was not aware that she was to provide frequent redirection to resident #4. During an interview with the Activities Director of the memory care unit on . . . . at 10:50 a.m., She confirmed Resident #4 did not have any identification on his person. She was aware of the regulatory requirement, but no residents met the criteria. The Activities Director was not aware of any resident deemed as an elopement risk. She said she was not aware that she was to provide frequent redirection to resident #4. During an interview with the DON on at 12:13 p.m., when she was asked why Resident #4 did not have identification on his person as required, she said she was not aware of the regulatory requirement. The DON said technically all of the residents in the memory care unit should have been deemed as an elopement risk, but formally they do not have anyone including Resident #4 deemed as an elopement risk. The DON said she was not aware that resident#4's service plan included language specific for frequent redirection in order to manage resident	A 032		

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A	Continued From page 21 #4's and prevent elopement. Follow up observation on at 7:42 a.m., revealed Resident #4 was not wearing any identification on his person. During an interview with the Interim Administrator on at 1:30 p.m., she said she has been in the community for couple of weeks and was not familiar with all the residents. She said she was aware of the regulatory requirement, and thought it was implemented. During an interview with the Receptionist on at 45 a.m. she said she was not given a list of residents deemed as an elopement risk. She said she was not aware of anyone with exit seeking behaviors. During an interview with the facility's physician on at 2:00 p.m., he said that technically all of the residents in the memory care unit are an elopement risk due to their During an interview with the Interim Administrator on at 3:30 p.m., she acknowledged there was no evidence on record of staff participation in elopement drills twice a year as required. The Interim Administrator confirmed that Resident #4 did not have any identification on his person as required. Class III	A 032		